the Association of American Indian Physicians (of which one of us is the president-elect). Such engagement helps maintain a Tribally centered approach by facilitating regular dialogue and transparency. AMC physicians have engaged in advocacy at the federal level, addressing issues related to access, quality, and partnership development. For example, AMC physicians recently helped establish the American Indian Medical Education Strategies Alliance, an organization working to increase implementation of graduate medical education (GME) models throughout the IHS. Steps taken by the IHS have been similarly encouraging. In 2025, after decades of advocacy by Tribes, the agency created a Division of Academic Affairs, in part to help standardize its approach to academic partnerships.

We believe actions in three additional areas would advance these partnerships. First, the IHS could formalize its stance on partnerships with AMCs by publishing a memorandum that describes opportunities, challenges, and needs related to these partnerships and endorses an approach to planning, implementation, and maintenance. Second, Congress could support IHS–AMC partnerships by appropriating dedicated funds, including for the new IHS Division of Academic Affairs. Congress could also pass the IHS Provider Expansion Act, which would support GME programs within the IHS, establishing a pathway to strengthen and expand IHS–AMC partnerships. Third, to facilitate long-term success, AMCs could develop strategies for sustainably funding and supporting the careers of faculty members involved in partnerships, in coordination with the IHS, Tribes, philanthropic organizations, and other partners, including with the Association of American Indian Physicians.

Partnerships between the IHS and AMCs represent one of many opportunities for advancing the health of American Indians and Alaska Natives. These initiatives must occur alongside efforts to ensure access to high-quality health care services and in the context of Tribal consultation that enshrines the priorities and perspectives of Tribes. The first phase of these partnerships has demonstrated that the focus of academic physicians — which includes providing high-quality care and engaging in process improvement, workforce development, and operational leadership — is of clear value to IHS hospitals that have struggled to recruit sufficient physician staff. The IHS, for its part, has shown determination to build and sustain these partnerships. AMCs and the IHS now have an opportunity to establish a sustained supply of talented physicians for sites where they are undeniably needed.

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The Epstein Files Transparency Act and the Health of Trafficked Children

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Human trafficking is usually framed as either a criminal justice issue or an individual tragedy. Yet it is also, fundamentally, a structural determinant of child health. Trafficking networks expose children to violence and physical and mental health problems that alter lifelong developmental trajectories. Traffickers control when and how trafficked children access health care, often delaying receipt of care by means of threats and intimidation. They also target children differentially according to age, sex, race, socioeconomic class, and geography, creating structural patterns of dis-

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advantage. In other words, human trafficking is a complex power system that functions as both a proximate and distal cause of poor child health. Yet health systems' responses remain focused on identifying and treating individual victims after the greatest harms have already occurred, rather than partnering with communities and policymakers to address the structural drivers of exploitation.

The Epstein Files Transparency Act (EFTA), signed into U.S. law in November 2025, brought these tensions to the fore.[1] Among the records that have been released are accounts of adolescent girls transported across jurisdictions and international borders, controlled by adults with financial and social power, and subjected to repeated sexual exploitation.[1] In some cases, these minors interacted with health care systems where no one recognized their circumstances. Given that policymakers vary in their willingness to investigate this global trafficking network and hold suspected perpetrators accountable,[1] the medical and public health communities face a choice: treat human trafficking as an unfortunate issue that lies outside its domain, or confront it as a health crisis that demands public health intervention.

Understanding trafficking in terms of public health leads to a new approach to clinical encounters with at-risk children. Clinicians are not individually responsible for solving human trafficking, nor is it medicine's role to investigate alleged traffickers. But if trafficking networks are a structural determinant of child health, then medicine has a responsibility at this level nonetheless. Treating trafficked children without addressing the exploitation that is the root cause of harm is tantamount to treating infection without eliminating the source. Without upstream intervention, more children will continue to be drawn into the same systems of harm.

The EFTA offers a rare opportunity to identify perpetrators, pursue accountability and punishment, and thereby prevent further emboldening of child trafficking. From a structural perspective, these measures contribute to the prevention of harm and illness. Thus, the relative efficacy of EFTA investigations can be understood as a modifiable upstream determinant of child health. This understanding brings new responsibilities within medicine's remit. It suggests that clinicians can and should act collectively, as part of professional organizations and public health institutions, to advocate for transparency in trafficking investigations and demand accountability for traffickers. Such advocacy remains an underrecognized lever for prevention.

In 2021, approximately 6.3 million people globally were trafficked for sexual exploitation, most of them women and children.[2] Exposure to violence during critical periods of development disrupts neurobiologic processes, including regulation of the hypothalamic–pituitary–adrenal axis. This disruption has negative long-term effects on cognition and emotional regulation. Similarly, repeated activation of stress pathways can alter brain architecture and increase risk for lifelong physical and mental health conditions.

Trafficked children frequently experience complex psychological trauma. Such trauma is characterized by repeated interpersonal harm and disrupted attachment[3] that negatively affect identity formation and the ability to form healthy relationships. Rates of post-traumatic stress disorder, depression, substance use, and suicidality are high in this population and often persist long after direct exploitation ends.[3] Sexual exploitation in particular introduces reproductive health risks, including unintended pregnancy and sexually transmitted infections, while physical violence can result in chronic pain, traumatic brain injury, disability, and death.[3] Disrupted education, poor health, and social stigma further contribute to intergenerational cycles of socioeconomic disadvantage. Children of parents who were once trafficked are at greater risk, both in childhood and later in life, for being trafficked themselves.[3]

Prevention is the defining aim of the public health field. Yet trafficking has consistently put public health institutions and experts on the defensive, where they address most harms only after they have occurred. Appropriate screening tools and training programs can help clinicians recognize trafficking, and these efforts are important. Yet studies consistently show that clinicians feel underprepared to identify trafficked patients and may lack the resources to respond appropriately.[4] Clinicians may also have reasonable fear of retaliation when suspected traffickers accompany children to their visits. These barriers can make clinicians less likely to report suspected trafficking or become involved in follow-up, which further stymies effective intervention.

Guidance issued by the Institute of Medicine in 2014 empha-

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sized that health care professionals are only one part of a coordinated, multisectoral response that includes survivor services, child welfare agencies, legal systems, and public policymakers.[5] The task for clinicians, then, is to align health systems within this coordinated response to work toward the goal of upstream prevention.

The EFTA, which has drawn renewed public attention to human trafficking, was passed with immense bipartisan support. It therefore creates a critical policy window for the medical profession to act, rather than merely react. Some governments have already acted on EFTA findings — for example, the Norwegian government has opened a criminal investigation into former Prime Minister Thorbjørn Jagland. Others, especially the U.S. government, have been criticized for a "flawed" release of Epstein-related records and a reluctance to confront powerful people who are implicated in the files.[1] This inaction is consequential. Trafficking networks thrive when the risk of detection and accountability is low.

Seeking transparency and accountability in trafficking investigations can therefore be understood as a preventive intervention. When trafficking networks are exposed, the conditions that enable them are disrupted, and consequences for perpetrators may deter future exploitation. Similarly, transparency and accountability are instrumental in empowering survivors to come forward, and can catalyze broader societal and policy responses. Viewed through this lens, there is a clear mandate for public health organizations and experts to move off the sidelines.

Health institutions (e.g., professional societies, journals, academic institutions, hospitals, and public health agencies) can issue position statements, convene interdisciplinary forums, and organize multisectoral coalitions to support transparency, accountability, survivor protection, and antitrafficking research. Individual health care professionals can use official civic channels to contact elected representatives and voice support for evidence-informed, prevention-centered policy responses. Clinicians should allow this moment to further heighten their awareness, approaching clinical encounters with a high index of suspicion for trafficking risk. If the Epstein files don't trigger a public health response, it seems legitimate to ask, what will?

Pediatrics, as a discipline, is well positioned to respond to this moment. Historically, pediatricians have not remained neutral when children's health has been at stake. Advocacy for vaccination, reductions in lead exposure, and child-labor protections have all required engagement with policy and, at times, confrontation with entrenched interests. This tradition reflects an understanding that protecting children's health requires addressing the structural conditions that place them at risk.

Medicine and public health have also demonstrated robust capacity to influence policy amidst crisis. Public health responses to tobacco's harms and HIV/AIDS, for example, required broad coalitions and sustained pressure on industry. The current moment demands similar leadership. Will the EFTA produce actions that dismantle trafficking networks and protect children? Or will attention fade without meaningful change?

The answer lies partly in physicians' hands. If prevention is medicine's guiding aim, then clinicians cannot remain passive. Medicine must commit itself to supporting transparency, demanding accountability, and fostering the conditions that allow all children to survive and flourish. To do anything less is to accept the indelible harms that human trafficking produces.

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